Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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MADISON WI 53701-0309

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DATE: March 31, 2004

TO: All Wisconsin Chronic Disease Program (WCDP) Participants
Chronic Renal Disease (CRD) Program

FROM: Wisconsin Chronic Disease Program (WCDP)

Please complete the enclosed *Financial Need Statement* [HCF 1189 (Rev. 02/04)] and return it to the Wisconsin Chronic Disease Program before May 30, 2004.

You must provide all information requested. We will return incomplete forms to you. *If you do not return your completed Financial Need Statement, claims for services after June 30, 2004, will not be paid.*

Please pay particular attention to the following items. If necessary, staff at your hospital or dialysis center will be able to assess your particular case and advise you in completing and mailing this form.

SECTION 4. INSURANCE INFORMATION - You must provide accurate, current insurance information. If your insurance has changed, please indicate the date your old insurance terminated and your new insurance began. If you have more than one insurance policy, list the second insurance company under Insurance #2. Please attach additional sheet(s) of paper with your insurance information if needed. Incomplete insurance information may cause your claims to be rejected.

SECTION 5. FINANCIAL INFORMATION.

Item 20. CURRENT MONTHLY/YEARLY FAMILY INCOME - Your eligibility will be determined by *current monthly or annual family income*. You must report all items (a. through l.) for all your immediate family to determine your total family income.

SUBMIT ADDITIONAL INFORMATION. You will need to submit the following items with the Financial Need Statement:

- Copy of last year's Wisconsin Income Tax return with all attachments.
- Copy of the most recent rental agreement OR property tax bill.
- Copy of your Wisconsin driver's license with current address OR State identification with current address OR Student ID (only for applicants under age 19).
- Copy of your Alien registration card issued by the INS if you are not a U.S. citizen.

- Copy of your Medicare card OR a copy of the letter of denial for Medicare from the Social Security Administration.

The following items may affect the level of WCDP reimbursement:

Effective July 1, 2004, participants whose anticipated annual income exceeds 200% of the federal poverty level will be required to spend a certain percent out-of-pocket before WCDP will reimburse their medical expenses. For more information please refer to the attached Income Deductible Chart. In addition, participants may be responsible for a percent of the charges for services received based on annual income and family size. For more information please refer to the attached Liability Chart.

Effective July 1, 2004, copayments for drugs will increase. For a month supply of a drug the copayment will be:

- $7.50 for each generic drug prescription paid for by WCDP.
- $15.00 for each brand name drug prescription paid for by WCDP.

Please send your completed Financial Need Statement to:

Wisconsin Chronic Disease Program
Attention: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

You will receive a new WCDP eligibility card after your financial information is updated. Please review your card for accuracy and report any discrepancies to the Wisconsin Chronic Disease Program. If you have questions, you may call 608-221-3701.

WISCONSIN CHRONIC RENAL DISEASE PROGRAM
FINANCIAL NEED STATEMENT INSTRUCTIONS

The Wisconsin Chronic Disease Program (WCDP) is a state-funded program whose purpose is to provide payment for chronic renal disease, adult cystic fibrosis and hemophilia home care supplies. The WCDP provides payment after all other payment sources have been used.

Completion of this Financial Need Statement is voluntary. However, if it is not completed, your eligibility for continued benefits cannot be determined. The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine continued eligibility and benefits for the Wisconsin Chronic Disease Program. The personally identifiable information collected on this Financial Need Statement will only be used to determine eligibility and benefits. Provision of your social security number is voluntary, however, your social security number is one of the unique identifiers used to identify you as a unique person in our claim system. Applicants who need assistance completing their Financial Need Statement should contact their treatment facility social worker.

Upon determination that an applicant is eligible for WCDP benefits, the applicant receives a letter of notification, and a WCDP identification card. WCDP participants are required to inform WCDP of any qualifying changes such as change in address, eligibility, mode of treatment, health insurance coverage, Medicare coverage, an up or down income change of more the 10%, or change in family size. Within 30 days of any qualifying change in circumstance, the WCDP participant is responsible for submitting any qualifying change(s) in writing to the WCDP. WCDP participants may be responsible for income deductibles, inpatient/outpatient deductibles, drug copayments, and coinsurance.

Instructions

Print clearly and follow these instructions carefully. Incomplete or illegible Financial Need Statements will be returned and delay determination of your eligibility. If you are an applicant's representative, provide the applicant's information. Make a copy of your completed Financial Need Statement for your records.

SECTION 1. APPLICANT INFORMATION

Item 1. Print your last name, first name and middle initial.
Item 2. Indicate your Social Security Number.
Item 3. Indicate your street address. You must indicate the physical residential address. A post office box alone is not acceptable.
Item 4. Indicate your home telephone number including the area code. If you do not have a telephone, indicate "None."
Item 5. Indicate your city, state and zip code.
Item 6. Indicate the county where you live.
Item 7. Indicate if you are a veteran. If yes, you should contact your county veterans service office for more information in obtaining state and federal veteran's benefits.
Item 8. Check "Male" or "Female".
Item 9. Indicate the month, date and year of birth.
Item 10. Answer "Yes" if you have dependent family members who are participants of the Wisconsin Chronic Disease Program. If you answered "Yes", indicate the name(s) and Social Security Number(s) of all dependent family members currently eligible for benefits from the Chronic Disease Program.
Item 11. Indicate your race/ethnicity by checking the appropriate box. This information will be used for statistical purposes only.

SECTION 2. RESIDENCY INFORMATION

Item 12. Check "Yes" or "No." If you answered "No", indicate the month, date, and year you moved to Wisconsin.
Item 13a. Applicants age 19 and over should provide copies of the following documents:

- Last year's Wisconsin Income Tax return with all attachments.
- The most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address.
- Alien registration card issued by the INS if you are not a U.S. citizen.

Item 13b. Applicants under the age of 19 should provide copies of the following documents.

- Parent's or guardian's Wisconsin Income Tax return with all attachments for the last year.
- Parent's or guardian's most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address **OR** school identification.
- Alien registration card issued by the INS if you are not a U.S. citizen.

If you are unable to provide either of the following documents, you may have your treatment facility social worker sign the residency verification.

- A copy of the most recent rental agreement OR property tax bill.
- A copy of your Wisconsin driver's license with current address OR state identification with current address OR Student ID (only for applicants under age 19).

Item 14. If you do not have these documents, explain why. Attach additional pages if necessary.

SECTION 3. MEDICARE AND WISCONSIN MEDICAID INFORMATION

Item 15. Check "Yes" or "No."
If you answered Yes, indicate your Medicare Part A (hospital insurance) and Part B (medical insurance) begin date(s). If your coverage has ended, indicate the end date(s). *If you currently have Medicare coverage, do not indicate a Medicare end date.* If you answered "No", proceed to item 16.

Item 16. Check "Yes," "No" or "N\A" (not applicable).

Item 17. Check "Yes" or "No."
If "Yes", indicate your Wisconsin Medicaid, BadgerCare or SeniorCare identification number. Wisconsin Medicaid may also be called Medical Assistance, MA, Title 19 or T-19.

Item 18. Check "Yes" or "No" to indicate whether you have applied for Wisconsin Medicaid, BadgerCare or SeniorCare in the past year, if you answered no in 17 item.
If "Yes", explain why you were denied eligibility for Medicaid, BadgerCare or SeniorCare.
Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP.

SECTION 4. SOCIAL WORKER SIGN OFF

Item 19. This section should be completed by the treatment facility social worker if the applicant has not applied for Wisconsin Medicaid, BadgerCare or SeniorCare.

SECTION 5. INSURANCE INFORMATION

Item 20. Check "Yes" or "No" to indicate whether you have private, group, HIRSP (Health Insurance Risk Sharing Plan) or other health insurance coverage for medical expenses. Do not include Medicare, Wisconsin Medicaid or BadgerCare, or the Wisconsin Chronic Disease Program here.
If "Yes", complete items 20a through 20o.

a. Indicate the name of the company through which you have health insurance coverage.
b. Indicate the telephone number, including the area code of the insurance company.
c. Indicate the name of the policyholder.
d. Indicate your relationship of the policyholder to you (e.g. wife, husband, self).
e. Indicate the policy number.
f. Indicate the group policy number.
g. Indicate the date the coverage began.
h. Indicate the date the coverage ended if you no longer have the coverage. If the coverage is still in effect, leave the coverage termination date blank.

i-o. Check "Yes" or "No" for each question. Refer to your insurance policy or contact your insurance company or representative for more information on your coverage.

If you have more than one insurance company, list the second insurance under "Insurance #2." Attach additional information if needed for current and past insurance for the last two years.

SECTION 6. FINANCIAL INFORMATION

Item 21. Indicate the number of dependent family members; include yourself if you are a dependent family member. Include all family members who may be claimed as dependents by the applicant for the purpose of filing a federal income tax return. This information is needed to determine your deductible for the Chronic Renal Disease program.

Item 22. Indicate your average total income by completing items a - l. Choose to complete either the average monthly totals OR annual totals.

If you are completing the "Average Monthly Totals" column, indicate the income received during a month in the most recent 12-month period. Do not use the highest or lowest monthly totals for income, use a monthly total that reflects an average amount of income. Indicate the month and year of this income (e.g. March 2004). If you are completing the "Annual Totals" column, indicate the income for the most recently completed calendar year. Indicate the calendar year of this income (e.g. 2003).

- **If you are claimed as a dependent on someone else's income tax return**, enter the current total monthly or annual income from that person's paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation received by that person. **Also, include any of these same types of payments or income received by you and everyone included in Item 21.**

- **If you are not claimed as a dependent by anyone else on their income tax return, but file your own income tax return and claim yourself as an exemption**, enter the current total monthly or annual income from your paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 21.**

- **If you are not claimed as a dependent by anyone else on their income tax return, and you do not file an income tax return of your own**, enter the current total monthly or annual income from your paycheck stub, all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 21.**

Item 20m. Add up the amounts in items 20a through 20l. and indicate the current total monthly or annual income.

Item 21. Indicate whether you anticipate your monthly income to increase or decrease more than 10%. If your monthly or annual income increases or decreases more than 10%, you must notify in writing the Wisconsin Chronic Disease Program of the change within 30 days.

Item 22. If you answered yes in item 21 explain why.

Item 23. Indicate your total gross family income based on last year's Wisconsin Income Tax return. If you did not file a state tax return leave this area blank.

SECTION 7. AGREEMENT AND SIGNATURES

Item 24. Indicate the medical facility from which you are receiving treatment.
Item 25. Enter signatures and date signed for applicant or applicant's representative if applicant is a minor.

Send the completed form to: Wisconsin Chronic Disease Program
Attention: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

If you have questions regarding the completion of this Financial Need Statement, please contact your treatment center social worker or call the Chronic Disease Program at (608) 221-3701.

Did you remember to:

- Sign and date the application.
- Include a copy of last year's Wisconsin Income Tax return with all attachments.
- Include a copy of the most recent rental agreement OR property tax bill.
- Include a copy of your Wisconsin driver's license with current address OR state identification with current address OR Student ID (only for applicants under age 19).
- Include a copy of your Alien registration card issued by the INS if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you may have your treatment facility social worker sign the residency verification.

- A copy of the most recent rental agreement OR property tax bill.
- A copy of your Wisconsin driver's license with current address OR state identification with current address OR Student ID (only for applicants under age 19).

CAUTION: Failure to fully complete your application and provide the requested documentation may result in delayed processing and eligibility determination.

WISCONSIN CHRONIC RENAL DISEASE PROGRAM
LIABILITY CHART

Liability for Services Received on July 1, 2004 and After Based on Current Policy

Deductibles: Before payment is made by the CRD Program for inpatient and outpatient services, you must meet an annual deductible.

For Dates of Services	Annual Deductible Amount Inpatient	Outpatient
7/1/04 - 6/30/05	$876	$100
7/1/03 - 6/30/04	$840	$100

Liability Based on Percent of Charges:

ANNUAL FAMILY INCOME	PERCENT OF CHARGES FOR WHICH PARTICIPANT IS LIABLE, BY FAMILY SIZE									
	Number of Dependent Family Members *									
	1	2	3	4	5	6	7	8	9	10
$ 0 - 7,000	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
7,001 - 10,000	2	1	0	0	0	0	0	0	0	0
10,001 - 15,000	4	2	1	0	0	0	0	0	0	0
15,001 - 20,000	7	4	2	1	0	0	0	0	0	0
20,001 - 25,000	11	7	4	2	1	0	0	0	0	0
25,001 - 30,000	14	10	7	5	3	2	1	0	0	0
30,001 - 35,000	17	13	10	8	6	4	2	1	0	0
35,001 - 40,000	20	16	13	11	9	7	5	3	2	1
40,001 - 45,000	24	19	15	13	11	9	7	5	3	2
45,001 - 50,000	29	24	20	17	15	13	11	9	7	5
50,001 - 55,000	34	29	25	21	19	17	15	13	11	9
55,001 - 60,000	39	34	29	25	23	21	19	17	15	13
60,001 - 65,000	44	39	34	30	28	25	22	20	18	16
65,001 - 70,000	49	44	39	35	32	29	27	25	23	21
70,001 - 75,000	55	49	44	40	37	34	32	30	28	26
75,001 - 80,000	61	55	50	46	43	40	37	35	33	31
80,001 - 85,000	67	61	56	52	49	46	43	40	38	36
85,001 - 90,000	74	68	63	59	56	53	50	47	45	43
90,001 - 95,000	81	75	70	66	63	60	57	55	53	51
95,001 -100,000	88	82	77	73	70	67	64	62	60	58
100,000+	97	91	86	82	79	76	73	71	69	67

Annual Cap Amount on Liability:

Annual Income	"Cap" Percent
Up to - $10,000	3%
$10,001 - $20,000	4%
$20,001 - $40,000	5%
$40,001 - $60,000	6%
$60,001 - $80,000	7%
$80,001 - $100,000	9%
$100,001 - and up	10%

* To determine who is a dependent family member, refer to the Application or Financial Need Statement Instructions.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
PHC 1193 (Rev. 02/04)

WISCONSIN CHRONIC DISEASE PROGRAM
INCOME DEDUCTIBLE

Under current policy, if your anticipated total family annual income is greater than or equal to 200% of the Federal Poverty Level (FPL), you are required to pay a percent of your income as out-of-pocket expense before the Wisconsin Chronic Disease Program will reimburse your medical expenses. This out-of-pocket expense is your income deductible.

The income deductible percentage is based on a formula using the FPL and the family size and income level you report to the Chronic Disease Program each year in the Financial Need Statement. To determine your percent of income deductible, refer to the income deductible charts.

For example, assume that you have an annual income of $30,000 and a family size of two. Your income deductible is .50% of $30,000 or $150. You must pay $150 out-of-pocket for eligible medical expenses before the Chronic Disease Program can begin to reimburse providers. You may calculate your own income deductible using the tables below. Contact your social worker or the Chronic Disease Program for assistance if needed.

Income Deductible is 0.50% of Family's Annual Income

200% - 250% of 2004 FPL	Family Size
$18,620 - 23,275	1
$24,980 - 31,225	2
$31,340 - 39,175	3
$37,700 - 47,125	4
$44,060 - 55,075	5
$50,420 - 63,025	6
$56,780 - 70,975	7
$63,140 - 78,925	8
$69,500 - 86,875	9
$75,860 - 94,825	10

Income Deductible is .75% of Family's Annual Income

251% - 275% 2004 FPL	Family Size
$23,275.01 - 25,602.50	1
$31,225.01 - 34,347.50	2
$39,175.01 - 43,092.50	3
$47,125.01 - 51,837.50	4
$55,075.01 - 60,582.50	5
$63,025.01 - 69,327.50	6
$70,975.01 - 78,072.50	7
$78,925.01 - 86,817.50	8
$86,875.01 - 95,562.50	9
$94,825.01 - 104,307.50	10

Income Deductible is 1.00% of Family's Annual Income

276% - 300% 2004 FPL	Family Size
$25,602.51 - 27,930	1
$34,347.51 - 37,470	2
$43,092.51 - 47,010	3
$51,837.51 - 56,550	4
$60,582.51 - 66,090	5
$69,327.51 - 75,630	6
$78,072.51 - 85,170	7
$86,817.51 - 94,710	8
$95,562.51 - 104,250	9
$104,307.51 - 113,790	10

Income Deductible is 1.25% of Family's Annual Income

301% - 325% of 2004 FPL	Family Size
$27,930.01 - 30,257.50	1
$37,470.01 - 40,592.50	2
$47,010.01 - 50,927.50	3
$56,550.01 - 61,262.50	4
$66,090.01 - 71,597.50	5
$75,630.01 - 81,932.50	6
$85,170.01 - 92,267.50	7
$94,710.01 - 102,602.50	8
$104,250.01 - 112,937.50	9
$113,790.01 - 123,275.50	10

Income Deductible is 2.00% of Family's Annual Income

326% - 350% 2004 FPL	Family Size
$30,257.51 - 32,585	1
$40,592.51 - 43,715	2
$50,927.51 - 54,845	3
$61,262.51 - 65,975	4
$71,597.51 - 77,105	5
$81,932.51 - 88,235	6
$92,267.51 - 99,365	7
$102,602.51 - 110,495	8
$112,937.51 - 121,625	9
$123,275.51 - 132,755	10

Income Deductible is 2.75% of Family's Annual Income

351% - 375% 2004 FPL	Family Size
$32,585.01 - 34,912.50	1
$43,715.01 - 46,837.50	2
$54,845.01 - 58,762.50	3
$65,975.01 - 70,687.50	4
$77,105.01 - 82,612.50	5
$88,235.01 - 94,537.50	6
$99,365.01 - 106,462.50	7
$110,495.01 - 118,387.50	8
$121,625.01 - 130,312.50	9
$132,755.01 - 142,237.50	10

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
PHC 1190 (Rev. 02/03) (Formerly PHC 0802)

Income Deductible is 3.50% of Family's Annual Income

376% - 400% of 2004 FPL	Family Size
$34,912.51 - 37,240	1
$46,837.51 - 49,960	2
$58,762.51 - 62,680	3
$70,687.51 - 75,400	4
$82,612.51 - 88,120	5
$94,537.51 - 100,840	6
$106,462.51 - 113,560	7
$118,387.51 - 126,280	8
$130,312.51 - 139,000	9
$142,237.51 - 151,720	10

Income Deductible is 4 .50% of Family's Annual Income

Greater than 400% 2004 FPL	Family Size
Greater than $37,240.01	1
Greater than $49,960.01	2
Greater than $62,680.01	3
Greater than $75,400.01	4
Greater than $88,120.01	5
Greater than $100,840.01	6
Greater than $113,560.01	7
Greater than $126,280.01	8
Greater than $139,000.01	9
Greater than $151,720.01	10

DEPARTMENT OF HEALTH & FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
HCF 1189 (Rev. 02/04)

STATE OF WISCONSIN
ss. 49.68 WIS STATS

WISCONSIN CHRONIC RENAL DISEASE PROGRAM
FINANCIAL NEED STATEMENT

READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE FORM

SECTION 1. APPLICANT INFORMATION

1. Name – Applicant (Last, First, MI)	2. Social Security Number (SSN) (optional)
3. Street Address – Applicant	4. Home Telephone
5. City, State, ZIP Code	6. County of Residence

7. Are you a veteran? ☐ Yes ☐ No	8. Sex ☐ Male ☐ Female	9. Date of Birth

10. Do you have any dependent family members who are participants of the Chronic Disease Program? ☐ Yes ☐ No
If Yes, indicate the names and Social Security Numbers (SSN) of all dependent family members who are participants of the Chronic Disease program.

Name _____ SSN _____

Name _____ SSN _____

11. Race/Ethnicity (Optional)
☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Hispanic (Mexican, Puerto Rican, Cuban or other Hispanic Culture)
☐ Black (Not of Hispanic Origin) ☐ White (Not of Hispanic Origin)

SECTION 2. RESIDENCY INFORMATION

12. Have you lived in Wisconsin for the last 2 years? ☐ Yes ☐ No
If you answered No, indicate the date you moved to Wisconsin _____ .

13a. Applicants age 19 and over should provide copies of the following documents.

- Last year's Wisconsin income tax return with all attachments.
- The most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address OR state identification with current address.
- Alien registration card issued by the INS if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you may have your treatment facility social worker sign the residency verification.

- A copy of the most recent rental agreement or property tax bill.
- A copy of your Wisconsin driver's license with current address or state identification with current address or Student ID (only for applicants under age 19).

13b. Applicants under the age of 19 should provide copies of the following documents.

- Parent's or guardian's Wisconsin income tax return with all attachments for the last year.
- Parent's or guardian's most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address OR state identification with current address OR school identification.
- Alien registration card issued by the INS if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you may have your treatment facility social worker sign the residency verification.

- A copy of the most recent rental agreement or property tax bill.
- A copy of your Wisconsin driver's license with current address or state identification with current address or Student ID (only for applicants under age 19).

14. If you do not have these documents, explain why.

SECTION 3. MEDICARE AND WISCONSIN MEDICAID INFORMATION

15. Do you currently have or have you had Medicare coverage? ☐ Yes ☐ No

If yes, indicate your Medicare eligibility dates below.

Part A (Hospital) Begin Date _____ Part B (Medical) Begin Date _____

Part A End Date _____ Part B End Date _____

16. Were you eligible for Medicare when you received your kidney transplant? ☐ Yes ☐ No ☐ N\A

17. Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP.
Are you currently eligible for Wisconsin Medicaid (Medical Assistance, MA, Title 19, T-19), BadgerCare or SeniorCare?
☐ Yes ☐ No
If yes, indicate your Medicaid, BadgerCare or SeniorCare identification number here_____.

18. If no, have you applied for any of these programs in the past year? ☐ Yes ☐ No

If yes, and you were denied eligibility for these programs, explain why.

_____.

SECTION 4. SOCIAL WORKER SIGN OFF

This section is to be completed by the social worker if the applicant is **not** enrolled in Wisconsin Medicaid, BadgerCare or SeniorCare.

19. Based on my knowledge of _____, I attest that he/she is not eligible for the programs listed above. Explain in the space provided why the applicant would be denied eligibility, where applicable.

Medicaid_____.

BadgerCare_____.

SeniorCare_____.

SIGNATURE – Social Worker	**Facility Name**	**Date Signed**

SECTION 5. INSURANCE INFORMATION

20. In the last two years have you had or do you currently have private, group, HIRSP, or other health insurance coverage for medical expenses? (Do not include Medicare, Medicaid or BadgerCare information here.) ☐ Yes ☐ No

If yes, complete the following information. If you have more than one insurance company, list the second company under Insurance #2. Attach additional information if needed for current and past insurance for the last two years.

Insurance #1		Insurance #2	
a. Name – Insurance Company	b. Telephone Number	a. Name – Insurance Company	b. Telephone Number
c. Name – Policy Holder	d. Relationship of Policy Holder	c. Name – Policy Holder	d. Relationship of Policy Holder
e. Policy Number	f. Group Policy Number	e. Policy Number	f. Group Policy Number
g. Coverage Begin Date	h. Coverage Termination Date	g. Coverage Begin Date	h. Coverage Termination Date

Indicate whether this insurance covers these services by answering each question. Answer each question.			Indicate whether this insurance covers these services by answering each question. Answer each question.		
i. Inpatient Hospital Service.	☐ Yes	☐ No	i. Inpatient Hospital Service.	☐ Yes	☐ No
j. Outpatient Hospital Service.	☐ Yes	☐ No	j. Outpatient Hospital Service.	☐ Yes	☐ No
k. Physician Services.	☐ Yes	☐ No	k. Physician Services.	☐ Yes	☐ No
l. Radiology Services.	☐ Yes	☐ No	l. Radiology Services.	☐ Yes	☐ No
m. Laboratory Services.	☐ Yes	☐ No	m. Laboratory Services.	☐ Yes	☐ No
n. Home Dialysis Supplies.	☐ Yes	☐ No	n. Home Dialysis Supplies.	☐ Yes	☐ No
o. Prescription Drugs.	☐ Yes	☐ No	o. Prescription Drugs.	☐ Yes	☐ No

SECTION 6. FINANCIAL INFORMATION

21. Indicate the number of dependent family members; include yourself if you are a dependent family member. _____

22. Indicate your current total income by completing items a - m either by **monthly OR annual totals.**	Average Monthly Totals Month / Year **OR** Annual Totals Year
a. Gross wages, salaries, tips, etc.	$ / $
b. Net income from non-farm self-employment.	$ / $
c. Net income from farm self employment.	$ / $
d. Social Security and/or Supplemental Security benefits.	$ / $
e. Dividends and interest income.	$ / $
f. Total of estate or trust income, net rental income and royalties.	$ / $
g. Cash public benefits (e.g. W-2 payments).	$ / $
h. Pensions, annuities and/or veteran's pension.	$ / $
i. Unemployment compensation and/or worker's compensation.	$ / $
j. Maintenance, alimony and/or child support.	$ / $
k. Non taxable interest (federal, state or municipal bonds).	$ / $
l. Nontaxable deferred compensation.	$ / $
m. Total Monthly OR Yearly income.	$ / $

23. Do you expect this income to change significantly from month to month or in the next year? ☐ Yes ☐ No

24. If yes, will your income be less or more than the total above? ☐ Less ☐ More
Explain why.

25. On last year's Wisconsin Income Tax return, what was your total gross family income before taxes? $ _____ .

SECTION 7. AGREEMENT AND SIGNATURES FOR CHRONIC RENAL DISEASE PROGRAM APPLICANTS

Eligibility for state reimbursement exists only insofar as certified by the Department of Health and Family Services (herein called the Department) or its fiscal agent upon: a) determination of the participant's Wisconsin residency; b) payment of Medicare part B premiums, if eligible for Medicare; c) receipt of a completed application, including verification by a nephrologist or transplant surgeon from an approved facility of having end stage renal disease. End stage renal disease is defined in Administrative Code 152 as "That stage of renal impairment which is virtually irreversible, and requires a regular course of dialysis or kidney transplantation to maintain life."

Pursuant to the authority of Wisconsin Statute 49.68 and 49.687 and the rules promulgated thereunder, the Department or its fiscal agent will, subject to the conditions named, reimburse an approved dialysis or transplant facility in the state or a dialysis or transplant center which is approved as such in a contiguous state, on behalf of the participant, for part of the cost of medical treatment specifically relating to chronic renal disease. Reimbursement will be made only for that portion of the allowable cost of medical services and medication remaining after all payment from other state programs, federal programs, and private health insurance coverage have been received and the participant's liability and deductibles have been determined. The participant's liability and deductibles will be based on income and family size.

If insufficient aid is available from other sources, the state shall pay the difference between the allowable cost and the sum of payment received and participant liability and deductibles. State payment shall be appropriately reduced if federal, state, private or other health insurance becomes available during the benefit period. The participant must inform the Department or its fiscal agent of all health insurance coverage and eligibility date.

The Department, the State of Wisconsin, and its officers or agents are released and discharged of and from all manner of action and actions, cause and causes of actions, suits, sums of money, judgment, claims, and demands whatsoever in law or in equity which the claimant, or his/her heirs, executors or assignees might have, or may hereinafter have, by reason of any injury or worsening of condition or death of the participant due to chronic renal disease, treatment or lack of treatment.

In order to establish my eligibility for state benefits, I authorize the medical facility (26) _____ to disclose information relating to my health condition or payment made for my health care to the Chronic Renal Disease Program.

I certify, to the best of my knowledge, all information provided on this form is true, correct, and complete. I understand that I will be denied reimbursement if I withhold information, provide inaccurate information, or refuse to provide information. I authorize release of any medical and financial information including certification for General Assistance, Medicaid or Medicare to the Wisconsin Chronic Disease Program necessary for processing claims and verifying services under the program. I agree to notify the Department or its fiscal agent in writing within 30 days of any change in name, address, income by more than 10%, insurance coverage, or family size. I agree to accept responsibility for the program's copayments and deductibles. I have read and consent to the above.

I understand that if I have not had a kidney transplant and I no longer require a regular course of dialysis to maintain life, I will not be eligible for benefits of the Wisconsin Chronic Renal Disease Program as of the date of my last dialysis. I will not be eligible for benefits until such time that I receive a kidney transplant or require a regular course of dialysis to maintain life. I also understand that if I am eligible for Medicare Part B, I must continue to pay Part B premiums in order to remain eligible for the Chronic Renal Disease Program.

I understand that benefits issued through the Wisconsin Chronic Disease Program are eligible for estate recover as defined in HFS 152.065(7). I understand that only Wisconsin residents are eligible for the Chronic Disease Program. By signing this form I am attesting that I am a Wisconsin resident as set forth in HFS 152.02(25).

27. SIGNATURE – Applicant (or applicant's representative if applicant is a minor)	Date Signed

DEPARTMENT OF HEALTH & FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
HCF 1143 (02/04)

STATE OF WISCONSIN
ss. 49.68 WIS STATS

WISCONSIN CHRONIC RENAL DISEASE PROGRAM
RESIDENCY VERIFICATION

Wisconsin Chronic Disease Program (WCDP) requires the information requested in this form to enable WCDP to determine participant eligibility, if the participant is unable to provide a copy of either of the following documents:

- A copy of their most recent rental agreement OR property tax bill.
- A copy of Wisconsin driver's license with current address or state identification with current address OR Student ID (only for applicants under age 19).

The use of this form is mandatory, if the participant is unable to supply the requested documents listed above. Failure to supply the information requested on this form may result in a denial of WCDP eligibility. Provision of your social security number is voluntary, however, your social security number is one of the unique identifiers used to identify you as a unique person in our claim system.

Personally identifiable information is confidential and is used for purposes directly related to WCDP administration.

SOCIAL WORKER INFORMATION	
1. Name - Social Worker	2. Telephone - Social Worker
3. Facility Name	
4. Facility Street Address	5. City, State, ZIP Code

PARTICIPANT INFORMATION	
6. Name - Applicant	7. Social Security Number (SSN) or WCDP Identification Card Number

Wisconsin Administrative Code 154.03 specifies in order to be eligible for the Chronic Renal Disease Program the applicant must be a resident of Wisconsin.

Based on my knowledge, I attest that_____ is a resident of Wisconsin. I have verified that his home address is in Wisconsin.

By signing this form I am attesting the participant is a Wisconsin resident as set forth in 152.02(25).

SIGNATURE- Social Worker	Date Signed